

Division of Health Care Facilities				
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: TN9301	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 03/07/2012
NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF SPARTA		STREET ADDRESS, CITY, STATE, ZIP CODE 508 MOSE DRIVE SPARTA, TN 38583		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
N 001	1200-8-6 Initial Comments During the annual Licensure survey conducted on March 3-5, 2012, at Life Care Center of Sparta, no deficiencies were cited under chapter 1200-8-6, Standard for Nursing Homes.	N 001		

Division of Health Care Facilities

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

STATE FORM

8899

OW8711

TITLE

Executive Director

(X8) DATE

3/23/12

If continuation sheet 1 of 1